



**NORTH CAROLINA WESTERN
MEMORANDUM**

Date: 2/7/2018
To: The Honorable Martin Reidinger
U.S. District Court Judge
From: Patrick Bradshaw
Sr. U.S. Probation Officer
Subject: Paul Aaron Tefft
Docket No. 0419 2:08CR00031
NOTIFICATION OF DEATH

Paul Aaron Tefft was sentenced in the Western District of North Carolina by Honorable Lacy H. Thornburg on 7/29/09 to 120 months imprisonment followed by 5 years Supervised Release. This memo is to inform you that Paul Tefft passed away on 1/19/2018. I am attaching a copy of the Death Certificate. We will be closing our supervision case file on the defendant due to his death.

Should you have any questions or concerns, please feel free to contact me at 828-267-3517.

Attachment

cc: Don Gast, Assistant U.S. Attorney
Frank G. Johns, Clerk of Court, Charlotte, NC
Scott Lunsford, Supervising U.S. Probation Officer

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
N.C. VITAL RECORDS

CERTIFICATE OF DEATH

REGISTRATION
DISTRICT NO. 002-00

LOCAL NO. _____

COUNTY OF DEATH Alexander

STATE FILE NO. _____

DECEDENT		DECEDENT'S LEGAL NAME		1a. FIRST <u>Paul</u>		1b. MIDDLE <u>Aaron</u>		1c. LAST <u>Tefft</u>		1d. SUFFIX		1e. LAST NAME PRIOR TO FIRST MARRIAGE			
TYPE/PRINT IN PERMANENT BLACK, BLUE- BLACK OR BLUE INK		aka		aka		aka									
7a. IF DEATH OCCURRED IN A HOSPITAL		7b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL		7c. FACILITY NAME (If not institution, give street and number)		7d. CITY OR TOWN		7e. COUNTY OF DEATH							
<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input type="checkbox"/> Hospice facility <input checked="" type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify)		Valley Nursing Center		Taylorsville		Alexander							
8. MARITAL STATUS		9. SURVIVING SPOUSE (Give name prior to first marriage)		10a. DECEDENT'S USUAL OCCUPATION (Do not use retired)		10b. KIND OF BUSINESS/INDUSTRY									
<input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Unknown				Cook		Restaurant									
11. SOCIAL SECURITY NUMBER		12a. RESIDENCE-STATE OR FOREIGN COUNTRY		12b. COUNTY		12c. CITY OR TOWN									
105-48-1213		NC		Cherokee		Murphy									
12d. STREET AND NUMBER		84 McGuire Street		12e. INSIDE CITY LIMITS <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		12f. ZIP CODE 28906		13. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
14. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death)		15. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino)		16. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)											
<input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade; no diploma <input checked="" type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input checked="" type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		<input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino		<input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese									
17. FATHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage)		Marlin Edwin Tefft		18. MOTHER/PARENT NAME (First, Middle, Last) (Last Name Prior to First Marriage)		Rose Anne Shaw									
19a. INFORMANT'S NAME		19b. RELATIONSHIP TO DECEDENT		19c. MAILING ADDRESS (Street and Number, City, State, Zip Code)											
Carleen Ayers		Sister		84 McGuire Street, Murphy, NC 28906											
20a. METHOD OF DISPOSITION		<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)		20c. LOCATION (City or Town and State)									
				Evans Crematory		Lenoir, NC									
21a. SIGNATURE OF FUNERAL DIRECTOR		21b. LICENSE NUMBER		21c. NAME OF EMBALMER		21d. LICENSE NUMBER									
<u>John Carter</u>		FD4174		Not Embalmed											
22. NAME AND ADDRESS OF FUNERAL HOME		Adams Funeral Home, LLC., PO Box 937, Taylorsville, NC 28681													
MEDICAL CERTIFICATION		23. Part I. Enter the <u>chain of events</u> (diseases, injuries or complications) that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology on lines b, c and/or d. Enter only one cause on a line. DO NOT ABBREVIATE.													
BURIAL/CREMATION PERMIT		Approximate Interval: Onset to death													
Medical Examiner: Authorization for Disposition/Transportation After the medical examiner completes and signs this burial transit, cremation, transportation or removal from the state. A copy of this form serves as a Burial/Cremation Permit.		IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ALS</u>		Due to (or as a consequence of)											
		b. _____		Due to (or as a consequence of)											
		c. _____		Due to (or as a consequence of)											
		d. _____		Due to (or as a consequence of)											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in PART I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. MANNER OF DEATH		26a. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. TIME OF DEATH (Approximate)		28. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		29. IF FEMALE: <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year							
26b. IF YES <input type="checkbox"/> Declined by Medical Examiner															
30. DATE PRONOUNCED (Month/Day/Year)		31a. DATE OF INJURY (Month/Day/Year)		31b. TIME OF INJURY		31c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		31d. PLACE OF INJURY—at home, farm, street, factory, office, building, etc.		31e. IF TRANSPORTATION INJURY SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)					
31f. DESCRIBE HOW INJURY OCCURRED															
32. CERTIFIER (Check only one)		31g. LOCATION OF INJURY (Street/Number/City/State)													
<input checked="" type="checkbox"/> Certifying physician/nurse practitioner/physician assistant – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner – On the basis of examination, and/or investigation, in my opinion death occurred at the time, date, and place, and due to the cause(s) and manner stated.															
33a. SIGNATURE AND TITLE OF CERTIFIER <u>John Carter MD</u>						33b. LICENSE NUMBER <u>33471</u>		33c. DATE SIGNED (Month/Day/Year) <u>1/23/2018</u>							
33d. NAME AND ADDRESS OF CERTIFIER (Print legibly) <u>J. Steven Carter MD 90 Sunnyside Ave Asheville</u>						36. DATE REGISTERED BY STATE									
34. FOR LOCAL REGISTRAR (Name) <u>Emily Blafield Deputy Registrar</u>		35. DATE FILED (Month/Day/Year) <u>1/23/2018</u>													
DATE CORRECTED (Mo/Day/Yr)				ITEM(S) CORRECTED:											
DATE AMENDED (Mo/Day/Yr)				ITEM(S) AMENDED:											